

Virginia Department of Health

Electronic Morbidity Reporting Portal

The Virginia Department of Health (VDH) Electronic Morbidity Reporting Portal (portal) provides health care professionals the ability to submit patient-based case morbidity reports as an alternative to the paper-based EPI-1 reporting mechanism. The elements included in this portal are similar to those on the paper EPI-1; however, some areas have been expanded to allow the most actionable information to be entered. In accordance with the Board of Health Regulations, this portal is the only mechanism for the reporting of Neonatal Abstinence Syndrome (NAS).

It is necessary to enter information on the person making the report. This information is both required and important in order to allow VDH to contact someone for further information on the patient if necessary.

This document identifies the fields contained in the portal. The initial step is for a provider to select the disease or condition they are reporting.

The screenshot shows the top portion of the 'Confidential Morbidity Report' form. At the top left is the VDH logo and 'VIRGINIA DEPARTMENT OF HEALTH'. At the top right are accessibility icons (AAA, +, -). Below the logo is the title 'Confidential Morbidity Report'. A paragraph of instructions follows: 'Please use the form below to submit reportable diseases or conditions to the Virginia Department of Health. If you are reporting a rapidly reportable condition, please call your local health department directly. Please enter as much information as is available in order to ensure that the health department is able to respond to your report effectively. Questions on the use of this electronic form for the submission of patient information can be directed to your local health department.' Below this is a section titled 'Reportable Condition' with a light blue header. It contains three fields: 'Disease or Condition' with a dropdown menu and a red asterisk warning '* must provide value'; 'Date of Onset' with a date picker showing '11/11' and a 'Today' button; and 'Date of Diagnosis' with a date picker showing '11/11' and a 'Today' button. All date pickers are labeled '(mm-dd-yyyy)' and 'M-D-Y'.

Patient Information

Patient Information	
First Name <small>* must provide value</small>	<input type="text"/>
Last Name <small>* must provide value</small>	<input type="text"/>
Middle Initial	<input type="text"/>
Date of Birth <small>(mm-dd-yyyy)</small>	<input type="text"/> <small>13</small> Today M-D-Y
Age <small>Enter age in whole years</small>	<input type="text"/>
Street Address	<input type="text"/>
City	<input type="text"/>
City or County of Residence <small>* must provide value</small>	<input type="text"/>
State	<input type="text" value="Virginia"/>
Zip Code	<input type="text"/>
Home Phone <small>xxx-xxx-xxxx</small>	<input type="text"/>

First Name - **REQUIRED**

Last Name - **REQUIRED**

Middle Initial

Date of Birth

Age

*If < 18 years, Parent/ProxyName - **REQUIRED***

Street Address

City

City or County of Residence - **REQUIRED**

State

Zip Code

Home Phone

Work Phone

Race

Ethnicity

Sex

If Female, Pregnant

Is the patient deceased

If Yes, Date of Death

Was the patient hospitalized for this illness

If Yes, Hospital Name, Date of Admission, MRN

Symptoms

If Reporting Syphilis

Your are reporting a case of syphilis, please enter the following information.

Clinical manifestations

Neurological manifestations Ocular manifestations Otic manifestations Late clinical manifestations

Syphilis only

Treatment – Non-STIs

Treatment

Treatment (including dates)

Expand

Free text treatment notation.

Treatment – STIs

Treatment	
Medication Name	<input type="text"/>
Medication Dose	<input type="text"/>
Medication Frequency	<input type="text"/>
Medication Duration	<input type="text"/>
Medication Route	<input type="text"/>
Treatment Date	<input type="text"/> <input type="button" value="Today"/> M-D-Y <small>(mm-dd-yyyy)</small>
<input type="radio"/> Click to add another medication	

Medication Name

If Other, Please Specify

Medication Dose

If Other, Please Specify

Medication Frequency

If Other, Please Specify

Medication Duration

If Other, Please Specify

Medication Route

Treatment Date

Physician/Clinical Information

Physician/Clinician Information	
Facility / Practice Name	<input type="text"/>
Physician First Name	<input type="text"/>
Physician Last Name	<input type="text"/>
Physician Street Address	<input type="text"/>
Physician City	<input type="text"/>
Physician City or County of Practice	<input type="text"/> ▼
Physician State	<input type="text" value="Virginia"/> ▼
Physician Zip Code	<input type="text"/>
Physician Phone	<input type="text"/> <small>xxx-xxx-xxxx</small>

Facility / Practice Name
Physician First Name
Physician Last Name
Physician Street Address
Physician City
Physician City or County of Practice
Physician State
Physician Zip Code
Physician Phone

If the Condition Reported is Neonatal Abstinence Syndrome (NAS)

Neonatal Abstinence Syndrome (NAS) Supplemental Questions			
<p>Exposure to opioids <i>in-utero</i> can result in different outcomes for the infant. Please select the outcome for this infant.</p> <p> <input type="radio"/> No clinical signs of withdrawal <input type="radio"/> Mild clinical signs requiring non-pharmacologic treatment <input type="radio"/> Severe clinical signs requiring pharmacotherapy </p>			
<p>Has a diagnostic test (e.g., hair, urine, meconium or umbilical cord) been ordered for this baby?</p> <p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know </p>			
Are any OTHER SUPPORTIVE ELEMENTS FOR NAS DIAGNOSIS present?			
	Yes	No	Unknown
Maternal history of substances known to cause NAS (e.g., an opioid)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Positive MATERNAL screening test for substances known to cause NAS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Positive NEONATAL screening test for substances known to cause NAS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No other supportive elements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What is the SOURCE OF THE SUBSTANCE CAUSING NAS, if known?			
	Yes	No	Unknown
Medication-assisted treatment (e.g. methadone, buprenorphine, or buprenorphine-naloxone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal prescription of an opioid pain reliever (e.g. hydrocodone, oxycodone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal prescription of a non-opioid (e.g. selective serotonin reuptake inhibitor)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescription opioid obtained WITHOUT a prescription (e.g. hydrocodone intended for someone else)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-opioid prescription substance obtained WITHOUT a prescription (e.g. benzodiazepine intended for someone else)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other non-prescription substance (e.g. illicit drugs other than heroin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No known exposure but clinical signs consistent with NAS (select this option ONLY if you did not select any other options)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (e.g. SSRIs, another "drug" used in the polysubstance instances)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Exposure to opioids in-utero can result in different outcomes for the infant.

Has a diagnostic test been ordered for this baby?

Are any OTHER SUPPORTIVE ELEMENTS FOR DIAGNOSIS present?

What is the SOURCE OF THE SUBSTANCE CAUSING NAS, if known?

Laboratory Information and Results – It is possible to enter up to 5 lab results

Laboratory Testing Performed must have a value of “Yes” to add laboratory testing results.

Laboratory Information and Results	
Laboratory Testing Performed <small>* must provide value</small>	Yes ▾
Specimen Collection Date <small>* must provide value</small>	<input type="text"/>  Today M-D-Y <small>(mm-dd-yyyy)</small>
Source of specimen <small>* must provide value</small>	<input type="text"/> ▾
Laboratory Test <small>* must provide value</small>	<input type="text"/> ▾
Test Result <small>* must provide value</small>	<input type="text"/> ▾

Specimen Collection Date

Source of specimen

 Other Source of Specimen

Laboratory Test

 If other laboratory test, please specify

Test Result

 Quantitative Test Result

If a test is ordered but not yet completed

If a Test is ordered or requested at time of Morbidity report entry and not completed, select “No” for Laboratory Testing Performed. In this instance, please complete the Comments section with the specimen collection date and the name of the reference lab where the test will be performed.

***** This is especially important for Monkeypox Morbidity reporting. *****

Laboratory Information and Results	
If the lab test has been requested and not completed, select "No" for Laboratory Testing Performed. Instead, in this instance, please complete the Comments section with: <ul style="list-style-type: none">• specimen collection date• name of the reference lab where the test will be performed	
Laboratory Testing Performed	
<small>* must provide value</small>	
No <input type="button" value="v"/>	
<input type="radio"/> Click to add another lab result <small>reset</small>	
Other Information	
Risk Situations	
<input type="checkbox"/> Food Handler <input type="checkbox"/> Patient Care <input type="checkbox"/> Child Care <input type="checkbox"/> Outbreak Associated	
<small>Check all that apply</small>	
Comments	
Specimen collection date: 10/12/2022 Reference lab: LabCorp	
<small>Expand</small>	

Risk Situations
Comments

Reporter Information

Reporter Information
Reporter First Name <small>* must provide value</small> <input type="text"/>
Reporter Last Name <small>* must provide value</small> <input type="text"/>
Reporter Title <input type="text"/>
Reporter Facility / Practice Name <input type="text"/>
Reporter Street Address <small>* must provide value</small> <input type="text"/>
Reporter City <small>* must provide value</small> <input type="text"/>
Reporter City or County <input type="text"/>
Reporter State <small>* must provide value</small> <input type="text" value="Virginia"/>
Reporter Zip Code <small>* must provide value</small> <input type="text"/>
Reporter Phone <small>* must provide value</small> <input type="text" value="xxx-xxx-xxxx"/>

Reporter First Name - **REQUIRED**

Reporter Last Name - **REQUIRED**

Reporter Title

Reporter Facility / Practice Name

Reporter Street Address - **REQUIRED**

Reporter City - **REQUIRED**

Reporter City or County

Reporter State - **REQUIRED**

Reporter Zip Code - **REQUIRED**

Reporter Phone - **REQUIRED**

In the event that a required field is not entered at the time that the reporter clicks the Submit button the portal will provide a pop-up notice of the missing information. Required information must be entered in order to complete submission of the report. Should the browser be closed prior to completing entry of all information, what had been entered up to that point will be saved; however, without a complete record it is possible that VDH will not be able to take action on that partial record.

The screenshot shows the 'Confidential Morbidity Report' form from the Virginia Department of Health. The form is titled 'Patient Information' and includes fields for First Name, Last Name, Middle, Street Address, City, and City or County of Residence. A pop-up message box is overlaid on the form, stating: 'NOTE: Some fields are required! Your data was successfully saved, but you did not provide a value for some fields that require a value. Please enter a value for the fields on this page that are listed below. Provide a value for... • First Name • Last Name'. An 'Okay' button is located at the bottom right of the pop-up message.